Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 8 Hydref 2013
Tuesday, 8 October 2013

Cynnwys
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Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are recorded in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mohammad Asghar	Ceidwadwyr Cymreig Welsh Conservatives

Jocelyn Davies	Plaid Cymru The Party of Wales
Mike Hedges	Llafur Labour
Sandy Mewies	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Julie Morgan	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Alistair Davey	Dirprwy Gyfarwyddwr Polisi a Strategaeth Gwasanaethau Cymdeithasol, Llywodraeth Cymru Deputy Director Social Services Policy and Strategy, Welsh Government
Paul Dimblebee	Swyddfa Archwilio Cymru Wales Audit Office
Albert Heaney	Cyfarwyddwr Gwasanaethau Cymdeithasol, Llywodraeth Cymru Director of Social Services, Welsh Government
David Sissling	Cyfarwyddwr Cyffredinol, Iechyd a Gwasanaethau Cymdeithasol/Prif Weithredwr, GIG Cymru Director General for Health and Social Services/Chief Executive, NHS Wales
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Fay Buckle	Clerc Clerk
Claire Griffiths	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 09:06.
The meeting began at 09:06.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everybody, and welcome to today's meeting of the Public Accounts Committee. There are just a few housekeeping notices. The National Assembly for Wales is a fully bilingual institution and, therefore, people should feel free to contribute to today's proceedings through either English or Welsh, as they see fit. Headsets are available for translation, and for sound amplification, for those who require it. I encourage everybody to switch off their mobile phones and other electronic devices, because, of course,

they can interfere with the broadcasting and other equipment. If there is an emergency, the ushers will guide us to the nearest appropriate exit and, hopefully, get us out safely. We have not had any apologies today.

Fframwaith Cenedlaethol ar gyfer Gofal Iechyd Parhaus y GIG: Tystiolaeth gan Lywodraeth Cymru
National Framework for Continuing NHS Healthcare: Evidence from the Welsh Government

[2] **Darren Millar:** We are taking evidence this morning, at the start of this particular inquiry, from the Welsh Government. Members will recall that the Auditor General for Wales gave us a briefing on his report in June, and we decided that we wanted to undertake a short piece of work as a result of that briefing. So, I am very pleased to be able to welcome to the table today David Sissling, director general of health and social services—or the chief executive, as he is more commonly known—for NHS Wales; Albert Heaney, who is the director of social services for the Welsh Government; and Alistair Davey, the deputy director of social services policy and strategy. Welcome to you all. Members had some particular concerns about the continuing healthcare issue, and we will be concentrating our questions on those, but, just to give you an opportunity, did you want to make any opening remarks, David?

[3] **Mr Sissling:** Very briefly. Thank you, Chair. First, I want to say how much we welcome the auditor general's report. We are very grateful for the insight, advice and recommendations within it. We have provided an evidence paper to the committee. Hopefully, that was helpful. The high level of overview is one that we have taken note of, we accept the report and the recommendations. We were pleased that the report recognised areas of progress and the benefits enabled by the framework. However, we recognise and acknowledge the need to further develop and strengthen the framework—not by a full rewrite, but by some revisions, refinements and developments. You will be pleased to hear that action has taken place since receipt of the report in June. We set up a number—I think that it was 12 or 13—of task and finish groups to look at various aspects. They have now, virtually, completed their work and the first draft of a revised framework, subject, as I said, to an extensive process of engagement, will be completed in the next week or so. It will be out for consultation for three months from November. There will be some period of time to assess the outcomes of that, but with a view to move, with pace, to the implementation and launch of a new framework in early summer. We mean 'early summer' as in June or July, rather than anything that drifts later into the summer. So, I just wanted, in the opening remarks, to say that the report has already stimulated action and that that will continue to be the case.

[4] **Darren Millar:** Thank you very much for that. We were pleased to receive the update that you provided, which did, indeed, directly address some of the concerns that I know that committee members have had. However, there was one part of the auditor general's report that you seemed to suggest that you did not fully concur with, and that was around the clearing of the backlog of community health council claims that the national project was dealing with. You suggested that you were very confident that all of these would be cleared by the target date next year, in August. Can you tell us why you are so confident?

[5] **Mr Sissling:** First, we have had assurances from Powys, the health board that is taking responsibility for this, at the most senior level, which is fine, but we have also looked at the statistics. In a sense, we have looked at the run rates—the rates at which it is currently clearing the claims. That provides a sort of trajectory with headroom, which means that Powys will actually complete its work at the current rate, which is now at a fairly stable level, by April. That gives some headroom, and that will then allow the movement from approval through to clearance, which goes back into health boards by June, except, we think, in the

most exceptional of cases.

[6] So, it will not be the case that Powys will complete its work on the last day of June. It will be approved but not cleared. It has actually done it so that it will be completing its work in April, which means a further two months to allow the more local conclusion of the process to take place. It has done that based on the current capacity that it has in place. As you appreciate, a multifaceted, multidisciplinary approach is necessary. It has special investigators, solicitors and clinical representatives, and it has plans in place to ensure that the team remains significantly in place during that period, the early part of 2014. In terms of the statement in the report of a 'significant' risk, we felt that while there will always be risk, we were more confident that it would meet the ministerial commitment.

[7] **Darren Millar:** So, you think that it will be complete in terms of the review et cetera by April, and then finalised, if you like, over the following two months.

[8] **Mr Sissling:** Yes.

[9] **Darren Millar:** Would it be fair to say that it is a bit like paying off a mortgage, as it were, in this respect? There is a lot of catch-up towards the end. A lot of the debt, if you like, is cleared towards the end of the period.

[10] **Mr Sissling:** In terms of the backlog—and colleagues may actually help with this—I think that it is well over 50% of the way there. As I say, its approval-to-clearance rate is now at a point that actually gives us reassurance. You have to look at the number outstanding and at how many it would need to clear each month. There is now a smooth path and the capacity is in place. There is no heroic expectation that it will all take place in April and that there will be some optimistic burst of activity. There is now a decline in the number outstanding in a way that you would want to see and the capacity is in place.

[11] Clearly, over the last couple of years, particularly over the last year, it has become much more proficient. The backlog, if anything, was the work required to assemble the information, some of which went back many years. So, with the development of the evidence base and the information base, and with the special investigators in place, it has now got into a standardised way of working and there is a proper flow in the process. Therefore, this process, to an extent, is a two-stage process. The Powys responsibility is to look at all of that information and, with the benefit of clinical and legal advice, develop to a position where it can actually approve or otherwise. Then it goes into the local system for final clearance. Of course, at that point, there will also be an interaction with the claimants.

[12] **Darren Millar:** Can you also tell us, Mr Sissling, about the rationale behind the decision to split the work between the national projects and the individual health boards? A certain number were hived off, if you like, to go into the national project, and the health boards retained some of the backlog for themselves, did they not? Can you just tell us a little bit more about that?

[13] **Mr Sissling:** The key date there is the publication of the framework in 2010. At that point there were cut-offs in place on a national basis, whereby claims previous to 2003 had to be made, or that was the final chance that people had to make them. At that point, the decision taken was that the best way to handle what would necessarily be a fairly significant pool of claims—the cut-off in a sense encouraged a significant cluster of claims—was to do it on an all-Wales basis by Powys, and that therefore was the justification for having a national approach to that retrospective grouping. The decision at that point was that all further claims would be done through the health boards individually. I think that there is some opportunity to reflect on that. Some of the claims that have come in subsequent to 2010 are historic—they relate to the period 2003-10. In preparing for this meeting, I thought that there was some

scope to ask whether we could use and develop the role of a national group to undertake some of that. What we do not want is a series of seven different backlogs that are managed in an inconsistent way. So, I am increasingly minded to say that we would develop the role of the national arrangements—in Powys or wherever they would be located. We have expertise there that seems, as I said earlier, to be handling this at an efficient pace and is applying itself to a secondary backlog that is developing. I think that that would probably be the most beneficial way to apply it.

[14] What we do not want to do, however, is to remove responsibility in any way from health boards for what is happening in real time—the here and now; the claims that are being made today and tomorrow. I think that that is reasonable. We do have a cluster or group of backlog from 2003 to 2010. What I would like to do is to very quickly see whether we can maintain the benefits of having a national approach to that, given that it seems to me to be the most efficient way to deal with it.

[15] **Darren Millar:** In terms of the backlog that is being dealt with by the health boards themselves—the pre-2010 backlog—what is the scale of that?

[16] **Mr Sissling:** I think that we would have the information; my colleagues are looking for it. I do not know whether we have that information to hand, but somebody will have it. We can bring that information to you.

[17] **Darren Millar:** You could send it to us.

[18] **Sandy Mewies:** My question is about process, really. Forgive me if I should know this, but I do not. We are talking now about two different ways of handling retrospective claims, but has there been at any time an onus on health boards to look at cases, as you would with PPI, for example, as the banks have been made to do, and say, 'Well, do you know what, we could have been wrong there?' or 'That was not handled properly'? Alternatively, has it been entirely left to people to make claims themselves? That is what I am thinking, given that many of these people—the relatives—are extremely elderly and perhaps not as savvy about this sort of thing as some people might be.

[19] **Mr Sissling:** I can understand the question. I think that the answer to that is that it is probably not as beneficial to the extent that your question might suggest it would be. I think that it probably has occurred on occasions. The process of undertaking reviews is initiated through a joint process that is led by the health boards and local authorities. In terms of retrospective cases, I think that it would be quite difficult to initiate retrospective reviews proactively. At the moment, it tends to work on the basis of claims made by the individual or by relatives.

[20] **Sandy Mewies:** Yes, I can see that it might be difficult, and it would be even more difficult now. We are looking at the past now, but we are also looking to the future. It seems to me that what is happening now is that the instant claims are being looked at to try to get them out of the way, and then you go back to the retrospective list. It seems to me that there should be some self-examination of what has happened.

[21] **Mr Heaney:** May I come in, Chair? Thank you very much for the question. It is very helpful. I would like to make two points—the first is to clarify the data numbers. In terms of the retrospective claims, we are looking at the completion of 2,450 initial claims, and at present 1,279 have been completed and closed.

[22] **Darren Millar:** Is that at the national project level?

[23] **Mr Heaney:** That is at the national project level.

[24] **Darren Millar:** What about the ones that—

[25] **Mr Heaney:** I will make sure that we come back to you on the local ones. One of the things that we are doing—and I think that this is really important in terms of the question—is revising the framework. Intensive work has been completed with all of the stakeholders and various task and finish groups. From that, they have come up with a number of proposals that will go into the revised framework for consultation. Those proposals begin to address some of the concerns that have been raised to enable us to be much better placed for the citizen in the future. One of the issues that are currently under consideration is to put a closure point on all of those claims of a maximum of two years from when the claim comes in. Again, in terms of getting that backlog cleared, we are quite intent on working with local health boards and to take that national overview.

[26] We have now established a national group, where we meet with the lead directors of primary, community and mental health. That group is one of our fora to look at the performance, and to look at the information that is developing, so that we make sure that we begin to get that consistency that the WAO report has highlighted to us, and also address some of the issues. That is an arena where you can look at some of the tricky cases that can perhaps be learned from, ensuring that we progress cases in a much more timely and responsible way.

[27] **Sandy Mewies:** Thank you, Chair.

[28] **Mr Sissling:** On the information that you asked about, Chair, the number of claims that have been received since August 2010, but which represent claims that relate to the period pre-2010, is 1,650.

[29] **Darren Millar:** So, they are the ones that are being dealt with by the health boards?

[30] **Mr Sissling:** Yes.

[31] **Darren Millar:** Okay. But new ones might pop up now and again?

[32] **Mr Sissling:** Yes. They will still pop up, which is one reason why I come on to this. We are currently considering the benefits of having some kind of rolling cut-off. At some point, it may be helpful just to create a bit of rigour in the system, to say that there will be a point at which claims that relate to a period prior to this need to be made by such and such a time, so that it is more manageable.

[33] **Darren Millar:** Okay, thank you for that. Jocelyn?

[34] **Jocelyn Davies:** In relation to the local health boards, can you explain why no timescale is set for those retrospective claims?

[35] **Mr Sissling:** I think that there should be, and we will be introducing one. I think that it is entirely reasonable that, as part of the revised framework—and the performance management arrangement that is introduced within that—we make it absolutely clear what the time frames are for the removal, or the handling, of all claims within the system.

[36] **Jocelyn Davies:** You will know that the report says that there has been confusion about responsibilities and so on in terms of these claims. Given that you are now reviewing the framework, it will be absolutely clear to local health boards exactly what is expected of them. Are you satisfied that there is enough staff at local health boards to clear the backlog?

[37] **Mr Sissling:** That is partly why I went back, as I said in response to the Chairman's first question, to the fact that I think that a more resilient way to deal with aspects of this would be to utilise a national approach, rather than a local approach. There is more resilience in having 30 people in one group than there is in having six lots of four or five people, because a loss of one can, obviously, have a disproportionate impact. Therefore, the answer to your question is that I think that there is more risk in the way that we are set up, hence why I think that we would be very wise to pursue the benefits of a national approach.

[38] **Jocelyn Davies:** I know that you mentioned the benefits, but I am confused now—is the Welsh Government going to be dealing with the backlog, or is the local health board going to do so?

[39] **Mr Sissling:** It will be the local health boards. The issue is whether they do so on a collective basis, as the health board in Powys is doing it—albeit with our oversight and, to an extent, our resourcing. As we have said in our evidence paper, we provide an injection of moneys to provide it with the ability to create the appropriate resources. It will be the health boards doing it. The issue post-June is whether there is simply a situation where each health board does this on its own, in terms of real-time and retrospective cases, or whether we build on the benefits of having a single approach across Wales for some elements of that. I think that that is where we are heading.

[40] **Mr Heaney:** The revised framework establishes a reporting responsibility on local health boards. So, as part of this process, what we are proposing to introduce is a self-assessment tool for local health boards. That will be completed. As part of that as well, in terms of challenge and peer review, a peer review process will be introduced to run alongside that, where there will be local health boards that will be led by and facilitated by—and this is where the Welsh Government is taking this responsibility—the Welsh Government, to bring together and to look at and to critically analyse that information. They will have a responsibility then for publicising an annual report. So, in terms of getting a whole picture, and moving in terms of timescales and responsibility, we will have a very clear picture, and we will be leading and measuring their performance, and the performance framework.

[41] **Jocelyn Davies:** You will be doing that.

[42] **Mr Heaney:** Yes, we will be.

[43] **Jocelyn Davies:** Are you able currently to monitor their progress?

[44] **Mr Heaney:** Yes, we are currently monitoring progress. We are currently meeting regularly, as I highlighted earlier.

[45] **Jocelyn Davies:** Okay. So, they have had 1,650 claims; how many of those have been cleared? You mentioned 1,650—

[46] **Mr Sissling:** I could not give you the total figure. I have information here that is for a briefer period, but we are very happy to give that information to the committee. We are getting a range of information about clearance levels and the number of challenges, because that is important—the extent to which the claimants challenge the position. In a sense, you want to know the outcomes, and we are getting that information very frequently to ensure that we can monitor and oversee the progress.

[47] **Jocelyn Davies:** You say that you are monitoring progress, but you cannot tell us how many have been cleared.

[48] **Mr Sissling:** I could not tell you how many have been cleared in total, only from the

point of view of a particular period. We have a month's figure that showed that 50 were cleared in that month, but I do not know how far we have gone into the total number. We are very happy to give that information.

[49] **Mr Heaney:** We will send that to you.

[50] **Jocelyn Davies:** You have that information, but you just do not know it off the top of your heads or you have not added it up.

[51] **Mr Sissling:** Yes; absolutely. We do not know it off the top of our heads. It is a monthly figure that shows how many were cleared in this particular month. I do not know what the cumulative figure is since 2010.

[52] **Jocelyn Davies:** So, the monthly figure is normally about 50, would you say?

[53] **Mr Sissling:** It was 50 in that particular month.

[54] **Jocelyn Davies:** What particular month?

[55] **Mr Sissling:** September 2013. It is up to date. We get information on a real-time basis.

[56] **Jocelyn Davies:** So, last month it was 50.

[57] **Darren Millar:** Thank you, Jocelyn. We turn to Julie and then we will come to Sandy.

[58] **Julie Morgan:** You have talked about the impetus that has been developed by the national team and about your view that that is the preferred way of going. Obviously, that depends on the expertise built up there. How sure are you that you are going to be able to keep this group together to see this through, so that there will not be any more delays?

[59] **Mr Sissling:** Powys is responsible for the maintenance of the team. I think that it has worked very efficiently to develop the team, and it currently has a recruitment and retention plan in place for nurse assessors and clinical investigators for legal support. It also has, for example, arrangements that provide people to work on a part-time basis or that provide recently retired nurses, who have necessary expertise, to come in. It is doing this in a way that recognises the nature of this work. It has been very successful in being able to respond to the inevitable ebbs and flows in such work. At the moment, I think that we are reasonably confident that if we decide to extend the national arrangement, it would give it more solidity, to be quite honest, in terms of the fact that it is not tapering down to June—it would have a continuing lifespan.

[60] **Julie Morgan:** In terms of the pressure to get through these numbers, do you think that any corners are being cut in order to settle these claims—for example, through giving the benefit of the doubt, or that sort of thing?

[61] **Mr Heaney:** I do not think that corners are being cut. It is a very complex assessment process—we take a multidisciplinary-team approach and we put in layers to assess and ensure that we are responding. The skills of the staff base have been commendable and have been supported by the Welsh Government to ensure that the capacity is there. We have been very intent on making sure that this is a fair process. We sent out interim guidance, again, following the Wales Audit Office's report. It is really important for the committee to be aware of that. Again, that strengthens the Welsh Government's commitment around eligibility and entitlement.

[62] **Julie Morgan:** In deciding the order of the claims—how they are dealt with—is consideration taken of the individual financial circumstances of the claimant?

[63] **Mr Heaney:** The decision was taken to look at them in chronological order, purely because of the volume that needed to be looked at.

[64] **Julie Morgan:** I have certainly found with individuals who come to me for help that they feel very strongly that the fact that their financial circumstances are very difficult means that they should be considered earlier than those in less stressful situations. However, you have considered that and decided on a chronological order.

[65] **Mr Heaney:** Yes; the decision that was made was that it would be on a chronological basis.

[66] **Julie Morgan:** Finally, why was no comprehensive business plan developed at the outset of the national project?

[67] **Mr Sissling:** A project plan was developed. At the time, that was felt to be sufficient. I think that it is, perhaps, reasonable to say that subsequent events demonstrated that it was not sufficient, in the sense that there had to be an injection of further resources to provide the capacity. Certainly, when I was involved, that was a very businesslike period when we looked at the capacity and the clearance rates. That was a decision that led to a significant injection of moneys into the process, to make sure that the resources were there, that we would get the benefits, and that we would achieve the clearance. It would be a shame, would it not, if we made a decision to inject significant sums of additional money from the Welsh Government and health boards and failed to deliver the deadline?

09:30

[68] **Darren Millar:** I will now bring in Sandy, and then Aled.

[69] **Sandy Mewies:** Thank you, Chair. I am just processing this—click, click, click, click, click. How are you going to ensure that people who are dealt with by the national project team or the health board are dealt with consistently and fairly? What I was thinking about was Mr Heaney's consultation on the revised framework. If, for example, someone suggested that cases should be looked at retrospectively and proactively, with a simple checklist sent out to people who had been involved, asking them to answer questions that might lead to a hint that their cases had not been dealt with properly, that would be shared, would it? I see that it would. Okay, so, that is really what I want to know: should health boards use exactly the same procedures as the national project, or should a common protocol for health boards and others be produced to process retrospective claims? I imagine that, if you are sending the framework out, that is what will guide both.

[70] **Mr Sissling:** Yes, exactly. We completely accept the thrust of your question. There should be more consistency, which enables fairness, sensitivity and compassion. So, some of the steps to achieve that will be common training for all of those involved, whether in the national or local arrangements. There will be a process of peer review. That will allow not just consistency, but a levelling up of practice, so we can learn from best practice. There will be groups established, with clear accountability at health board level, and identified accountable directors, to make a report four times to the health board each year and, annually, a report that we will receive. We will use that as the basis to examine the performance of individual health boards and make sure that there is consistency between health boards and a group that we will establish in the Welsh Government to oversee the process. We will have a performance framework that will have a number of different areas of focus, including

clearance rates. We will be looking at assessment measures, user and carer satisfaction, complaint levels, and the degree to which plans were made in advance of, rather than retrospective to, care arrangements. That is because we should be anticipatory rather than doing it after long, extended stays in hospital. Completion of assessments at homes should feature much more in what we are doing, and workforce development. So, we will have a performance framework that allows us to make sure that there is good practice consistently across Wales. Together, those elements will provide assurance that there is fairness and good practice that is consistently applied.

[71] **Sandy Mewies:** Thanks, Mr Sissling. I have a question that is perhaps obvious to everyone else. One of the problems that there has been in the past is that the definition of continuing healthcare and who should be paying for it has been extremely unclear. In fact, it has been a battlefield, in many ways, between the health service and social services. Is there a clear definition now that these people will be working to, and will they be trained on the implications of that clear definition?

[72] **Mr Sissling:** Absolutely. There is a clear definition, and the training will ensure that that is understood and applied in a consistent way. The other thing that we will be doing is placing much more emphasis on patient information and public information. At the point of admission to hospital or at GP practices, we want to make sure—and, in a sense, this is not just a professional exercise—that patients, relatives and other members of the public have an understanding of what continuing healthcare means against funded nursing care. In a sense, we are bringing the patient into the process much more centrally, rather than them being, at times, a passive recipient of a process. So, this is about having much more information, better communication, better engagement and better public information.

[73] **Mr Heaney:** I would like to add to that, if I may, Chair. Public information is crucial to citizens being able to be informed. Alongside this, in terms of getting that consistency across Wales, we are introducing a screening tool. That screening tool will be helpful in capturing, for the first time, vulnerable groups that, perhaps, have often not been informed. So, for those citizens who have funded nursing care as part of their review process, one of the proposals that we are bringing forward is that the screening tool will be used to see whether they should be assessed for continuing healthcare. Previously, that may not have been considered. Another important aspect for us is modifying the decision support tool. The decision support tool, as you will know, is a support mechanism to bring together the assessments to inform decisions. That will also, helpfully, take away some of the anomalies that have been in the system to date.

[74] **Darren Millar:** We will want to talk a bit more about the decisions in a few moments. Thank you, Sandy. Aled is next, and then I will come to Jenny.

[75] **Aled Roberts:** Rwyf yn derbyn yr hyn a ddywedodd Mr Heaney.

Aled Roberts: I accept what Mr Heaney said.

[76] **Mr Heaney:** My headphones are tied up.

[77] **Darren Millar:** We will give you a second. Is it all working? The translation is on channel 1, is it not?

[78] **Aled Roberts:** Iawn. Rwyf yn derbyn yr hyn a ddwedoch chi am y targed y dylai pob achos gael ei ddatrys o fewn dwy flynedd a bod hynny o dan ystyriaeth. A gaf i droi at yr achosion newydd sydd wedi codi ers 2010, a gofyn a oes gennych chi ddarlun

Aled Roberts: Okay. I accept what you said about the target that every case should be resolved within two years and that is under consideration. May I turn to the new cases that have arisen since 2010, and ask whether you have a full picture of how many cases are

cyflawn o faint o achosion sydd o flaen y byrddau iechyd ar hyn o bryd?

before the health boards at present?

[79] **Mr Sissling:** We get information on a monthly basis about the cases that come in from the health boards. So, the answer to that is 'yes'. We are strengthening our scrutiny of those.

[80] **Aled Roberts:** Dywedoch fod 1,650 o achosion cyn 2010, a bod tua 50 y mis yn cael eu datrys ar hyn o bryd. Felly, bydd tair blynedd cyn i'r rheini i gyd gael eu datrys. A yw nifer yr achosion newydd yn fwy na'r nifer sy'n cael eu datrys yn fisol gan y byrddau iechyd ar hyn o bryd? A oes rhestr o achosion ers 2010 sy'n cynyddu o fis i fis?

Aled Roberts: You said that there were 1,650 cases before 2010, and that around 50 a month were being resolved at the moment. So, three years will have passed before all of those are resolved. Is the number of new cases greater than the number of those being resolved monthly by the health boards at the present? Is there a list of cases since 2010 that is increasing on a monthly basis?

[81] **Mr Sissling:** We would have to provide that information. What would help the committee is a detailed breakdown of the additions to the list, namely the retrospective ones and the pre and post-2010 ones—in a sense, the run rates against both of those and how many are clearing, so that we can see the net position in terms of the overall increase or decrease.

[82] **Mr Heaney:** Just to clarify, the two-year timescale is covering those cases as well. We are introducing a clear, definitive point where those should be resolved, rather than, as you say, drifting into two or three years.

[83] **Aled Roberts:** Yn yr achosion hynny sydd wedi codi ers i'r fframwaith gael ei gyflwyno, a ydych chi'n monitro faint o deuluoedd sydd wedi herio'r penderfyniadau yn yr achosion hynny?

Aled Roberts: In those cases that have arisen since the framework was introduced, are you monitoring how many families have challenged the decisions in those cases?

[84] **Mr Sissling:** Yes, we are. We have regular information about the number of challenges, which goes to the directors of primary and community care. So, that information is obviously of value in understanding the outcomes of the process.

[85] **Aled Roberts:** Pa fath o ganran—

Aled Roberts: What sort of percentage—

[86] What sort of percentage are we talking about at the moment?

[87] **Mr Sissling:** I would have to supply the information subsequently.

[88] **Darren Millar:** Jocelyn, you wanted to come in on this.

[89] **Jocelyn Davies:** It concerns me a little bit because you say that you are monitoring but you are not able to tell us much in terms of the figures, the percentage that you have cleared or how many challenges there are. You knew that you were coming today. Is somebody monitoring this? Why are you not able to tell us today?

[90] **Mr Sissling:** Obviously, we are here with some information, but regarding the level of detail that you are asking for, we would be happy to supply in very short order the information regarding the clearance of current and retrospective claims and any challenges.

[91] **Darren Millar:** Mike, you wanted to come in.

[92] **Mike Hedges:** I want to follow on from what Jocelyn Davies said. I would have thought that, alongside last month's numbers, you would have had a cumulative amount, so that you would know how you were doing all the time. Coming here this morning did not come as a shock to you. So, I am bemused as to why you did not think that the cumulative amount was useful.

[93] **Mr Sissling:** Apologies if that is the case but, as I said, we are very happy to provide that information to the committee subsequent to the meeting.

[94] **Jocelyn Davies:** [*Inaudible.*]—rather than sustain how you were monitoring.

[95] **Darren Millar:** I think that the point has been made and we will expect these figures very soon after the end of today's meeting. I want to move on now to look at the decision support tool.

[96] **Jenny Rathbone:** Age Cymru and the Alzheimer's Society think that people with dementia living in Wales have been disadvantaged as a result of the tool that was used in Wales being different to that used in England. What evidence do you have one way or the other?

[97] **Mr Heaney:** I will pick up on that. The Wales Audit Office report was very clear and helpful to us. It clearly was the decision support tool that led to a distinction where Welsh citizens were disadvantaged. Our proposal is to remove that and to change that. The new decision support tool will be based on the same level as is taking place in England. I think that that will be welcomed by citizens and groups that are interested in making sure that citizens get the same rights and entitlements. That will open up opportunities for people suffering with dementia because our threshold will change in that regard. It will also enable us to have cross-border standards that are equivalent rather than differential.

[98] **Jenny Rathbone:** What makes you think that the clinical advice that you were given in Wales was incorrect? The reason why people with cognition issues were deemed to be 'high' as opposed to 'severe' in England was that people in the late stages of dementia required less clinical input in their care. What reason is there to assume that the Welsh advice was wrong and that the English advice was better?

[99] **Mr Heaney:** The evidence came from different sources, but also from the discussions that took place in the task and finish group. The task and finish group looking at this particular matter was very clear in looking at the fact that the threshold that we had set was higher and that that should change. For us, as officials, that was felt to be the right approach. This is for consultation, so it will ultimately be decided through that consultation process. However, we believe quite strongly that that is the right direction of travel. It takes away the difference between 'high' and 'severe' for us because to get the eligibility criteria to that level was more challenging and ruled some citizens out. That will be caught up in the new model.

[100] **Jenny Rathbone:** Did the task and finish group have any people from England on it?

[101] **Mr Heaney:** I do not believe that it had anyone from England on it; it was very much a Welsh specialist group. As the committee has heard today, there were a number of task and finish groups that were set up, comprising specialists. They certainly had specialists from Wales who have a wider understanding and look across both UK and international learning. I have a high level of confidence in the players who were participating.

[102] **Jenny Rathbone:** On whichever side of the border people live, it is fine to have different policies, but the clinical decision-making tools need to be rigorously the same both sides of the border—they need to be tried and tested both sides of the border, do they not?

One of the other issues that is a bit concerning is the evidence given by the health board leads that multidisciplinary teams lack the confidence to make decisions around continuing healthcare and, as a result, are too reliant on the decision support tools and adding up the score, as opposed to looking at the patients and their needs. That is quite worrying. Why is that?

[103] **Mr Heaney:** One of the issues is that it is sometimes about professional confidence or a lack of professional confidence. It is sometimes about relying too much on a tool and a score. What we have proposed and created is a change to the decision support tool. We are very clear that that is only a support mechanism—it is an enabler. It is professional judgment that is crucial. Therefore, in terms of the training, we will be putting on regional training. We will make sure that those professionals working across this field are given the skills. We have some very skilled professionals, but we want to make sure that we have consistency, so we will be building on our training approach.

09:45

[104] As I mentioned earlier, we are introducing the new screening tool, and we are introducing a revised decision support tool. We see those very much, with the training, being the building blocks to enable professional judgment around the citizen, so that those citizens under continuing healthcare should receive continuing healthcare based on their health needs, making sure that it is a rounded, collated picture. I therefore think that some of the modifications that have taken place in the decision support tool are enablers and are helpful in that process.

[105] **Jenny Rathbone:** But it is still astonishing, as the whole purpose of a multidisciplinary team is that people can draw on each other's expertise.

[106] **Mr Heaney:** Of course.

[107] **Jenny Rathbone:** It sounds like you have the wrong individuals—ones who are not lateral thinkers or able to listen to and accept the advice of the expert in a particular aspect.

[108] **Mr Heaney:** From looking at the information and knowing the professionals in the field, I think that it is about developing consistency and professional confidence. That is very much what the new revised framework will be aimed at. We have some very skilled professionals out in the field, and it is important to acknowledge that, but, equally, in terms of the complexities of managing this particular assessment process and coming to good decisions, it is very important that we equip them and give them the skills to be able to do that. We believe that the tools and the revisions to the tools will be helpful and will strengthen the position in Wales, and that will then enable the practitioners and the professionals involved in making clinical decisions to have a stronger base on which to make those decisions.

[109] **Mr Sissling:** Another thing we will be doing, in the new year, will be to pilot the new assessment process, which will streamline the process to make it quicker. That will probably help to overcome some of the difficulties that you have raised. There will be a clearly identified co-ordinator for the process. Also, rather than having a series of meetings, which can at times not be the easiest settings in which to develop rapid outcomes, the co-ordinator will organise and collate responses from different professionals and take the role of co-ordinating and coalescing those responses. The co-ordinator will also maintain contact with the families and the carers throughout the process, and there will probably be one meeting with a much more streamlined use of the decision support tool, rather than page after page. Reflecting on the process, it probably has become a little bit driven by the paper-based approach, rather than being one that is driven by patient need. So, in the new year, we will be

piloting that, and that obviously goes alongside the consultation period. Presuming a successful outcome to the consultation, the pilot scheme will then embed that in the revised framework, to be applied from next summer.

[110] **Darren Millar:** Many people would be very pleased to hear about the greater level of consistency, if you like, in the decision support tool and the scoring between England and Wales. In terms of the time frame for the implementation of the change, when will that be? It will not apply retrospectively, will it? It will be for new cases going forward.

[111] **Mr Sissling:** That is right.

[112] **Darren Millar:** Will that be from the new year, as part of the new regime?

[113] **Mr Sissling:** It will be from post-consultation. We need to consult on these proposals, so, as I said, we are consulting in November, December and January, and we will take some time to assess the outcomes, taking into account the results of the piloting work, because we also want to get the health boards applying the checklist that the Wales Audit Office proposed so that we can road-test that in the new year. We are really keen to make sure that when we get to this point in early summer, we have something that we can mobilise with the benefit of having trialled and piloted these new ways of undertaking the process.

[114] **Darren Millar:** There will be a bit of a sense of injustice, no doubt, for those people who perhaps were scored on the previous decision support tool, compared to those who might be scored post the summer. Are you giving any consideration to the impact of that?

[115] **Mr Sissling:** I think that we will, and we obviously need to take appropriate advice about that in terms of how we create the new framework.

[116] **Darren Millar:** Okay. Thank you for that. I am going to come to Aled, then Sandy, then Oscar.

[117] **Aled Roberts:** A wyf wedi deall yn iawn, felly, o ran argymhelliad yr archwilydd cyffredinol y dylai byrddau iechyd ddefnyddio teclyn hunanasesu i weld a ydynt yn ymateb i ofynion y fframwaith, y byddwch yn ymgynghori ar hynny yn hytrach na'i gwneud yn ofynnol yn syth i'r byrddau iechyd ddefnyddio'r teclyn hwn?

Aled Roberts: Have I understood you correctly, with regard to the recommendation by the auditor general that health boards should use a self-assessment tool to see whether they are responding to the requirements of the framework, that you will consult on that rather than making it a requirement from the outset for the health boards to use this tool?

[118] **Mr Sissling:** It is a bit of both. It will be consulted upon, but, in a sense, we do not want to wait—there is a danger of always waiting to do something; so, why not get ahead and test it out in the new year to see if there are benefits to health boards in using it? If we presume that the outcome of the consultation will be to adopt that, the health boards will have had some experience of using it already and will be in a position where they will have done a self-assessment so that they can move on with the insight that that offers.

[119] **Aled Roberts:** Felly, a fydd pob bwrdd iechyd yn defnyddio'r teclyn o'r flwyddyn newydd ymlaen, er fy mod yn derbyn y bydd yn rhaid gweld hefyd beth yw canlyniad yr ymgynghoriad?

Aled Roberts: Therefore, will every health board be using this tool from the beginning of the new year, although I accept that we will have to see what the result of the consultation is as well?

[120] **Mr Sissling:** Yes.

[121] **Aled Roberts:** Os ydynt yn ei ddefnyddio o'r flwyddyn newydd ymlaen, sut bydd Llywodraeth Cymru yn monitro'r defnydd? Rwy'n siŵr eich bod yn ymwybodol bod beirniadaeth o'r ffordd mae'r gwasanaeth iechyd neu'r byrddau iechyd yn defnyddio rhai o'r teclynnau hunanasesu mewn meysydd eraill, felly byddem am wybod a yw'r hunanasesiad yn un cywir.

Aled Roberts: If they use it from the beginning of the new year onwards, how will the Welsh Government monitor its use? I am sure that you are aware that there has been criticism of the way that the health service or the health boards use some of these self-assessment tools in other areas, so we would like to know whether this self-assessment is the most appropriate one.

[122] **Mr Heaney:** Thank you very much for the question. We will have a formal process whereby the self-assessment must be completed by local health boards within a three-month period. That three-month period will be the time when they will do that work. Alongside that, we will have the peer review—so, we will have the peer review challenge. This is a process where we are bringing together different ways of ensuring that we get that consistency. We will also have a formal reporting in the annual report where that will be fed through. So, in terms of being publicly available, we will have information that will provide assurances. We are also developing the performance framework, and that is where that monitoring will be. Today, we apologise for bringing our monthly data—we should have brought our collected data. In the future, that information will be very much at the tip of our fingers, and we assure you that that is very much the mechanism. The annual performance report will be produced in September of next year. That will be the first annual report by local health boards.

[123] **Aled Roberts:** Os oes diffygion yn y ffordd mae rhai o'r byrddau iechyd yn ymwneud â'r achosion hyn, ni fydd cynllun gweithredu ar lefel leol tan ar ôl yr adroddiad blynyddol ym mis Medi 2014. Neu, a ydych yn meddwl y bydd gofyn ar fyrddau iechyd i gyflwyno cynlluniau gweithredu cyn hynny?

Aled Roberts: If there are shortcomings in terms of how some of the health boards get involved with these cases, there will be no action plan at a local level until after the annual report in September 2014. Or, do you think that health boards will be required to introduce action plans before that?

[124] **Mr Sissling:** I think that the action plans need to be continuous and they need to evolve. The health boards are required to do so for their boards, and you must remember the role of the boards in holding their endeavours to account. The health boards, through their accountable executive lead, will be providing quarterly reports to the health boards. Our requirement will be that those are not simply passive monitoring reports, but reports that lead to actions.

[125] As a further point of assurance, we will collate the local annual reports into a national report. There will be a national conference or forum within which they can be discussed, and we can pick up, share and apply best practice. Therefore, at any point, we will be raising the bar in terms of practice. So, it is not a static process—it will be a dynamic process where we will be raising standards and expectations each year.

[126] **Sandy Mewies:** The auditor general's report makes the point that there is a lack of strategic leadership on continuing healthcare nationally and within health boards. It also makes the point that the complex care steering group has had little impact so far. What do you think can be done to strengthen strategic leadership and the work of the complex care steering group to support dealing with continuing healthcare in the future?

[127] **Mr Sissling:** The arrangements that we will put in place—these are significantly, if not fully, in place—include accountable lead directors for each health board. So, there will be a clear point of leadership within each health board at director level. That has perhaps been

one of the issues, that the lead has not always been at director level. They will be responsible for reporting to their boards quarterly and to us annually on the quality and outcomes of applying the framework. The leads currently meet with us on a monthly basis; that, of course, is an opportunity for us to make sure that everybody is on track and on the right path to the delivery of good standards. We will make sure that that continues as a means by which we can provide appropriate supervision, and intervention, where necessary. We are creating a group that will have responsibility for oversight of this at a Welsh Government level and, of course, we have the performance framework, which, in a sense, is the vehicle through which we can make sure that there is appropriate performance, driven by the regular report and the monthly reports on the kinds of things that we described earlier. So, I think that a fresh approach is needed, and we will introduce that—we are already introducing that—and develop more formality with it.

[128] **Mr Heaney:** To complement Mr Sissling's comments, there is a requirement on the lead director to produce a quarterly report for the local health board. So, in terms of the accountability of local health boards, there will be a route directly through to the local health board, which I think adds greater value. The other dynamic issue, which perhaps we have not covered this morning, was continuing healthcare and the responsibility of local health boards. There are many citizens who may not fall within continuing healthcare, but who fall within health and social care needs. One of the care directions that we are also taking is to have an equivalent designated officer from local authorities, so we have clear points of contact as to who, where there are concerns, can resolve them and make sure that that is a seamless process for citizens.

[129] **Sandy Mewies:** However, Mr Sissling, you have no hesitation in saying that intervention from the Welsh Government will be taken appropriately and when necessary.

[130] **Mr Sissling:** Absolutely, yes.

[131] **Darren Millar:** Mike, you wanted to come in.

[132] **Mike Hedges:** Yes. You mentioned 'meeting with us'. Do you mean yourself and the gentlemen you have here with you at the moment, who are at a senior level, or do you mean more junior people in the organisation?

[133] **Mr Sissling:** I am sorry, can you—

[134] **Mike Hedges:** You said, 'meeting with us'. Who is 'us'? Is it you three gentlemen who are sitting here or is it more junior people in the organisation? It indicates the level of seriousness that you give to it.

[135] **Mr Sissling:** It will be at this level, and there will be a facility, on an individual health board level, if particular issues arrive, for them to be taken through the accountability meetings that I have with each of the health boards, their chief executives and their colleagues. This merits interaction at a senior level. I think that one of the lessons from the past is that perhaps we have not got that level quite right.

[136] **Mike Hedges:** It sets out how important you think it is, does it not?

[137] **Mr Sissling:** Exactly.

[138] **Mike Hedges:** Just to clarify, what you are saying is that you three will be the people meeting with them.

[139] **Mr Sissling:** Yes. I will be meeting with health boards, as I do very frequently.

Albert and Alistair will be meeting specifically about continuing healthcare on a regular basis.

[140] **Darren Millar:** Okay. Jocelyn, you wanted to come in, and then I will come to Oscar.

[141] **Jocelyn Davies:** Yes. You told Sandy Mewies that there would be no hesitation in intervening, if necessary. Has there been, to date, any need to intervene with any local health board with regard to this issue?

[142] **Mr Sissling:** We have had a whole series of discussions. It depends on what you mean by 'intervene'—

[143] **Jocelyn Davies:** Well, that is up to you, is it not? That is for you to tell us.

[144] **Mr Sissling:** In the sense that we have detected variability, we have raised issues with particular health boards and asked them to pay attention to particular issues. The information that we get shows that there is variation in terms of clearance rates, and, clearly, with some, we have asked them to put more resources into place to develop greater leadership focus and to reassure us that they are moving to a position where they have the right capacity to meet demand. In the sense that that is intervention, yes, there has been.

[145] **Darren Millar:** Okay, thank you. Oscar is next and then I am going to come to Jenny.

[146] **Mohammad Asghar:** Thank you, Chair. My question relates to expenditures and pressures. What steps has the Welsh Government taken to ensure that the financial pressures on the NHS are not influencing CHC eligibility decisions?

[147] **Mr Sissling:** I think that a number of things are guidance, and our requirement has been consistent and particularly clear, but this is a process that is based on individual needs, and there is a statutory context within which this applies. We have made it absolutely clear in our guidance. We also need to recognise that the assessment and approval, or otherwise, of a claim are made through a multidisciplinary, but predominantly clinically led, process. That then goes to another part of the system where there is a decision on adoption/commissioning. That cannot overturn the decision that the clinicians have made. They can ask for further information, but they cannot veto it, and the suggestion that they might do so on financial grounds, I certainly would not accept. Certainly, they could not do it. They would have to send back some information and be asked for consistency. The further things that we monitor are complaints. We look at challenges on a monthly basis. The development of peer review and a performance framework will allow us to see whether there are any significant discrepancies between health boards that would indicate that perhaps there are different thresholds, but the training that we are providing and the degree to which this is a framework with consistency in terms of the methodology, I think, should protect against that. I just do not think that that would happen. I do not think that health boards would do that.

10:00

[148] **Darren Millar:** I have two Members whom I still want to bring in to ask some important final questions. In view of the time, I ask Members to be brief with their questions, and witnesses to be brief in their responses. Jenny is next and then Jocelyn.

[149] **Jenny Rathbone:** Up until now, the lawyers have had a field day, with four out of five appeals being overturned. The Wales Audit Office puts a huge question mark over the numbers of people that you think that you will need to train. My concern is: why are there not key people here who are experts in CHC? Whether they are central or localised is obviously

up to you. The peer review is obviously essential so that all health boards feel confident that decisions made in Swansea are similar to the ones made in Wrexham. You mentioned it in your earlier response. How is that going to work, exactly, in the light of the fact that you have not quite decided whether you will have a national CHC decision-making mechanism or not?

[150] **Mr Sissling:** Irrespective of that, I think that we have indicated our developing thinking. The task groups have paid particular attention to this. One of the task groups is on the panels and the process to make sure that we embed consistency in the way that we set up the system and develop the colleagues who play roles in this. It is in every single task group, and whether it is on learning disability, mental health, funding arrangements, matters of process or the focus on dementia, we want to make sure that we embed consistency and standardisation into the process. We then follow in with the peer review and the performance framework, which I think provides the inputs, outcomes and outputs, so that we can make sure that there is consistency to the best possible extent.

[151] **Jenny Rathbone:** How will you make sure that you still do not have charities that advocate for a particular condition saying that you can get a better deal in England?

[152] **Mr Sissling:** In a sense, there is a path of convergence with some elements of the English system. I think that we would want to make sure that what happens in Wales is measured by the standards that we set—the ministerial approved standards in Wales. We will always take advantage of opportunities to learn from any other part of the UK. We have information, which was in the Wales Audit Office report, about the comparisons with not just England, but Scotland and Northern Ireland. I am sure that it would be wise to continue to network and see whether there are opportunities to learn not just from England but from other UK systems.

[153] **Darren Millar:** The final question is from Jocelyn.

[154] **Jocelyn Davies:** Families sometimes tell us that they feel irrelevant, that they are not sure what is happening, and that they do not understand the process. What steps are being taken to encourage more extensive engagement with people and their families or carers during the assessment process?

[155] **Mr Sissling:** First, the point that I would make is that, with a streamlined process, it is always easier if there is a single point rather than multiple points of interaction. So, a single co-ordinator who can organise the, at times, complicated process of interactions with healthcare professionals and local authorities and also be a single point of communication with the family or the individual. I think that that is important. Then, a step change in terms of communication, in terms of admission to hospital, when it becomes clear that longer term care may be needed, in terms of any meetings to make sure that people feel comfortable and not disempowered in any way by the meetings that they go to, and when there is an agreement—an agreed outcome—to the whole process. It is a matter of paying attention to that, and, through our training, making sure that we are sensitive to individual needs at a time that can be of significant anxiety and worry.

[156] **Jocelyn Davies:** What about raising public awareness about eligibility, and so on, and even the existence of CHC?

[157] **Mr Sissling:** That falls into this issue of communication in hospitals, with GPs. There is a question mark over whether it should be more general. It is quite a complex issue; I am not sure whether it would register at a time when people are in situations where it might become a possibility. Of course, the other big thing is to work with the third sector, which, as we know, has a tremendously important role and has contacts and networks into the communities where this might be an issue.

[158] **Jocelyn Davies:** You said just now that you did not believe that local health boards would make decisions based on financial grounds, because of the training and the consistency and so on. Will you tell us why the number of complaints to the ombudsman from families is rising every year?

[159] **Mr Sissling:** I—

[160] **Jocelyn Davies:** I think that the report says that it has gone up from 33 to around 50 cases in the last three years.

[161] **Mr Sissling:** I think that we need to look at the nature of the complaints. I suspect that some of them relate to frustrations in terms of timescales—

[162] **Jocelyn Davies:** Have you looked at the nature of those complaints?

[163] **Mr Sissling:** I see many, yes—

[164] **Jocelyn Davies:** You could tell us, then, why they—

[165] **Mr Sissling:** I think that many of them relate to frustration with the process and the time frames that have been undertaken. Clearly, there are issues, some of which are complaints about the outcomes and the extent to which the process was applied in the particular case. I have not detected in my particular observation that there have been issues to do with the financial aspects and that those have dominated the process.

[166] **Jocelyn Davies:** Okay. Is there a pattern?

[167] **Mr Sissling:** There are some trends and themes within it. Obviously, time frames are an issue, as is the extent to which all due factors were taken into account, and the decision. There are clearly a number of different patterns and themes within the process.

[168] **Jocelyn Davies:** Okay. Thank you.

[169] **Mr Heaney:** I would just add that we have worked very closely with the ombudsman's office in terms of the revisions to the framework and learning from those complaints that have come forward as well.

[170] **Jocelyn Davies:** Okay. Thank you.

[171] **Darren Millar:** Aled, you had a minor question. Please be very brief.

[172] **Aled Roberts:** Nid wyf am fod yn or-feirniadol, ond cefais e-bost neithiwr gan berson a oedd yn cwyno am y drefn hon, nid o ran yr amserlen—roedd yn eithaf bodlon â'r amser a gymerwyd i ddelio â'r mater, ac nid oedd ychwaith yn cwyno am y penderfyniad, ond yr hyn oedd yn amlwg oedd nad oedd yn deall yr hyn a oedd yn cael ei drafod.

Aled Roberts: I do not want to be over critical, but I had an e-mail last night from someone who was complaining about this system, not in terms of the timetable—they were quite satisfied with the time that it had taken for the issue to be dealt with, and they were not complaining either about the decision, but what was evident was that they did not understand what was being discussed.

[173] **Mr Sissling:** That emphasises the point that we made and that will be embedded in the new approach, which should start immediately—it should not be a matter for consultation. The emphasis will be on good communication and early communication with individuals,

with carers, and with relatives and advocates to make sure that there is a proper understanding. I understand the point.

[174] **Darren Millar:** Okay. On that note, that draws us to the end of this particular item on our agenda. Thank you David Sissling, Alistair Davey and Albert Heaney for your attendance today. We look forward to receiving the further information that has been referred to during the course of this evidence session. Of course, you will have the chance to correct any inaccuracies in the record, which will be sent to you once it has been completed. Thank you very much indeed.

10:08

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting

[175] **Darren Millar:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi) and (ix).

[176] There are no objections, so we will move into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:08.
The public part of the meeting ended at 10:08.